



Papua New Guinea



# A GENDER AUDIT of the NATIONAL STRATEGIC PLAN on HIV/AIDS 2006-2010

UNDP  
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## Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Clinics
ARV	Anti – retroviral
Aus AID	Australian Agency for International Development
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CSW	Commercial Sex Worker
GIPA	Greater Involvement of People with AIDS
HBC	Home Based Care
HIV	Human Immuno deficiency Virus
IMR	Institute of Medical Research
MDG	Millennium Development Goal
MSM	Men Who Have Sex with Men
MTCT	Mother to Child Transmission
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NCD	National Capital District
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NHASP	National HIV/AIDS Support Project
NRI	National Research Institute
NSP	National Strategic Plan
OVC	Orphan and Vulnerable Children
PACs	Provincial AIDS Councils
PLWHA	People Living with HIV/AIDS
PNG	Papua New Guinea
PMGH	Port Morseby General Hospital
S&D	Stigma and Discrimination
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNIFEM	United Nations Fund for Women
UPNG	University of Papua New Guinea
VCT	Voluntary Counseling and Testing

# National Strategic Plan on HIV/AIDS (2006-2010) Of the Government of Papua New Guinea

## Gender Audit Report

“Despite women’s higher biological vulnerability, it is the legal, social and economic disadvantages faced by women and girls in most societies that greatly increase their vulnerability. Therefore, gender sensitive approaches are key when designing prevention programs” (UNAIDS, Global report, 2004, p.68)

The HIV epidemic has generated an unprecedented level of global response but with few and small pockets of success. Even as sub-Saharan Africa is struggling to halt the growth of the epidemic and cope with its impact, the situation is turning grim in many other parts of the world. The most worrying estimates are now coming from Asia and the pacific region, home to 62 per cent or nearly two thirds of the world’s population. Four countries of this region have a heterosexual epidemic with above 1 % HIV rate among women attending antenatal clinics – Thailand, Cambodia, India and Papua New Guinea - creating a sense of urgency to check the spread of the epidemic (UNAIDS 2004). At current estimates the region already has 19 per cent of the world’s HIV infected population. One in five new infections worldwide is appearing in Asia and the Pacific with roughly half of these among young people. For example in the ESCAP region by the end of 2001, 2.6 million of the 7.5 million PLWHA were young people aged 15-24 (ESCAP, 2003).

Unless checked, Asia is predicted to have a problem as large as that in Africa currently. A common factor linking the African HIV epidemic to the epidemic in Asia is the predominantly heterosexual nature of HIV transmission in both the regions. As in Africa, so in Asia, the face of the epidemic is increasingly female, young and impoverished. The fact sheet based on UNAIDS statistics reveals the gendered dimension of the epidemic.

- *As of December 2003, women accounted for nearly 50% of all people living with HIV worldwide.*
- *In sub-Saharan Africa 57% of adults infected with HIV are women, and among the young people, 75% are women and girls.*
- *In Asia and South-East Asia women account for nearly 28% of the infections*
- *Infection rates among women are rising consistently through out the world- in 1997 women were 41% of people living with HIV, but by 2003 the percentage increased to 50%. In Oceania the rise was from 17% in 2001 to 19% in 2003.*
- *A study in South Africa found significantly higher rates of HIV infection among women who were physically abused, sexually assaulted or dominated by their male partners*
- *In Thailand a study found 75% of HIV infected women were likely infected by their husbands. Nearly half of these women reported sex with husbands as their only risk behavior*
- *In some African countries married 15-19 year old females have higher HIV infection levels than non married but sexually active females of the same age group*
- *In a survey in Uganda one in four widows reported their property was seized after their partner died*

*(Based on UNAIDS Report on the Global AIDS Epidemic, 2004)*

## HIV/ AIDS in Papua New Guinea

Before attempting a gender audit of the national Strategy Plan on HIV/AIDS of PNG, it is important to understand the PNG HIV epidemic in terms of its defining characteristics. These are perhaps not unique to PNG alone but are certainly pertinent to be reminded about in relation to the design and implementation of the national response. The **first** defining feature is that the epidemic in PNG is sexually transmitted and predominantly heterosexual while sex, sexuality and, sexual health issues are shamed and moralized in society. Harsh judgments prevent open and informed discussion about the epidemic in communities. The **second** is that, as elsewhere so also in PNG, the epidemic is driven by inequities- inequities of gender, class, structure- underscoring the point that the epidemic is not a health and medical issue. It's about poverty, about gender and about lack of choices. It therefore requires a broader developmental approach. The **third** worrying feature is that the epidemic is increasingly becoming younger and feminized accentuating gender inequalities and urging for gender mainstreaming of all policies and programs. The **fourth** reality is that political and social leadership in PNG is yet to commit its wholehearted support to the national response whereas, global evidence indicates that strong leadership and honest political commitment are vital to making a difference. And, the **fifth** is that stigma, discrimination and human rights violations accompanying the epidemic are huge barriers to prevention efforts - accelerating transmission and keeping the true scale of the epidemic hidden.

### Looking Through the Gender Lens: PNG women more vulnerable to HIV than men

The key vulnerabilities in relation to gender and HIV/AIDS in PNG are:

- Women and girls represent an increasing proportion of those infected with HIV in PNG, with a near even sex ratio among the adult HIV infected population
- Adolescent girls and young women with HIV, aged 15-24, outnumber boys and young men of comparable age by more than two times
- Cross-generational sex involving younger women and older men, and domestic and sexual violence, are strong co-factors in increasing women's vulnerability to HIV
- Customary practices – bride price, polygamy, widow inheritance - and gender inequities in customary laws enhance women's vulnerability in a number of ways
- A variety of commercial and non-commercial sexual networks that are not mutually exclusive, link high risk behavior groups to the general population
- Condom use is low and contingent on type of partner - lowest with regular partner
- For many women marriage is not proving to be a protective institution
- Unequal gender relations and biased gender norms prevent women from accessing information, seeking treatment for sexual infections, and negotiating for safer sex
- Highly unequal sexual partnerships – 'tu kina bus' sex workers, family driven sex work, 'wet lunch sex' ( 'Duk glas kar man'), marriage, polygamous marriages
- Dominant ideologies of masculinity encourage men to have multiple sex partners and conform to the 'predatory' view of male sexuality that subjugate women through coercive, violent sex

- Higher mobility of men and situations of predominantly male working/ living settings expose men to sexual abuse, violence and forced same sex behavior
- Knowledge gaps in relation to sex and sexuality and cultural inhibitions in accessing related information on the part of both men and women deny them safer sex options
- Women are disproportionately burdened in HIV through care giving, experiencing greater levels of stigma and discrimination , and partner violence

## Gender Analysis of the National Strategy Plan of the National AIDS Council of PNG

### The Process

This report presents a gender audit of Papua New Guinea's National AIDS Council's Strategy Plan, 2006-2010. The work was accomplished in two phases. Phase one, was carried out over a period of four weeks, from September 16- October 14, 2004, by the Consultant while stationed for this purpose in the PNG capital city of Port Moresby. This phase involved a series of direct consultations with key architects of the NSP, major donor partners and stakeholders, and a review of existing and relevant literature and documents on HIV/AIDS in PNG. A draft gender audit report was submitted to NACS at the end of this phase. Phase two, undertaken from May 10 to June 6, 2005, involved a series of dissemination workshops and consultations with key stakeholders and partners to receive feedback and finalize the draft audit report. The time frame and the TOR for the two phases are given in Appendix 1.

The final gender audit report is based on,

- a) Review of the official documents of the National AIDS Council (NAC Strategy plan document 2006-2010)
- b) Review of published and unpublished research literature on sex, sexuality, and gender in PNG society
- c) Scan of official documents of the government departments of Health, Planning, Community affairs, PMO,
- d) Key informant interviews with government officials in departments of Health, Correction, Planning, Statistics, Community Affairs, Law, and NAC Advisory Committee Members, Members of the NHASP, Team leaders/Program officers of NAC
- e) Key informant interviews with program in charge / staff of AIDS NGOs, Church based NGOs, individuals providing care to PLWHA
- f) In-depth interviews with men and women living with HIV/AIDS
- g) Interviews with health professionals- doctors and nurses, HIV counselors
- h) Interviews with key UN functionaries ( UNAIDS CPA, UNICEF, UNFPA, UNDP)
- i) Feedback from stakeholder workshops and individual consultations

The report is limited by time constraints and the lack of baseline data in most focal areas of the national policy. The lack of generic research on the social and gender dimensions of the HIV epidemic in the country was another limiting factor. The gaps have been plugged to the extent possible through personal interviews with a number of key

stakeholders such as, PLWHA, health professionals, HIV counselors and community based/ NGO workers.

## **The PNG National Strategic Plan on HIV/AIDS**

The National Strategic Plan on HIV/AIDS, 2006-2010, for combating the epidemic in PNG, was drafted through a yearlong consultative and participatory process in 2003. The need for a new national plan was considered imminent following the UN/USAID review of the country's National HIV/AIDS Medium Term Plan (1998-2002) carried out in December 2002 (UN/USAID, 2002). With the above review as a starting point, and based on the recommendations of a situational analysis workshop held in June 2003, the new plan has identified seven priority areas for mounting a fresh response to the epidemic. These seven areas are: Treatment, counseling, care and support; Education and prevention, Epidemiology and surveillance; Social and behavioral change research; Leadership, partnership and coordination; Family and community support; and Monitoring and evaluation. The plan seeks to be guided by principles of human rights, evidence backed decision making, transparency and accountability, and cultural contextualization (PNG NSP, 2006-2010).

### **The Place of gender in the NSP**

Gender is not one of the focal areas identified in the National Strategy Plan (NSP) of PNG (See App. 2 for definitions of key concepts related with gender). Nor was gender specified and identified as a critical dimension of the epidemic in PNG in the UN/USAID 2002 review. This despite strong and compelling evidence cited on the serious nature of socio-economical, sexual, cultural and other forms of vulnerabilities of young girls and women in PNG. This gap in the national plan is striking given that the country's epidemiological profile shares several features with those of countries in the sub-Saharan Africa where the gender factor is recognized as critical to addressing the epidemic and gender analysis and mainstreaming as key strategies in the individual country responses. The similarities in the epidemiological profiles of PNG and countries of Africa are worth highlighting here.

- “Nowhere is the epidemic’s ‘feminization’ more apparent than in sub-Saharan Africa where 57% of adults infected are women, and 75% of young people infected are women and girls. Several social factors are driving this trend. Young African women tend to have male partners much older than themselves – partners who are more likely than young men to be HIV infected. Gender inequalities in the region make it much more difficult for African women to negotiate condom use. Furthermore, sexual violence, which damages tissues and increases the risk of HIV transmission, is widespread, particularly in the context of violent conflict” (UNAIDS, 2004, p.22).

- The most current statistics for PNG reveal that the gap in the HIV prevalence rates for men and women is fast narrowing. Statistics for the period 1987 – 2004 (September) report 51.4 % HIV infected men compared to 48.6% infected women (NAC & NDoH, Quarterly Report, Sept.2004). The annual statistics for the year 2003 showed a reverse trend recording a still stronger feminized epidemic with 52.4% HIV infected women as against 47.6% infected men during the year (NAC & NDoH, Quarterly Report, December, 2003). Refer Table 1. A similar trend can be observed from the report of the third quarter in 2004 (July to September)- of the total 362 HIV cases recorded by sex during the quarter, 51 % were women and 49 % men (NAC & NDoH, Sept. 2004). The trends suggest that women may soon outnumber men. See Fig 1.

The age/sex distribution of HIV infections reveals a very strong Africa like pattern with more girls and young women infected than boys and young men of comparable age suggesting, as in Africa, that girls and younger women are engaging in sex with men older to them in age. See Figs. 2 and 3. Cumulative HIV infection rates up till 2003 among girls (aged 10-19) and young women (aged 20-24) are three times and two times higher respectively, than that among boys and young men in the same age brackets (Fig.2). During the year 2003, HIV infection among women aged 20-24 was more than two times that among same age men at 23% and 9% respectively. Refer Table 1 and Fig.3 (NAC & NDoH, quarterly report, December 2003). During the quarter of July- Sept. 2004, HIV infection among women aged 15-24 was more than two and a half times than that among men of same age (37.6% and 13.9 % respectively) Refer Table 2. Available provincial level data (this data is highly inadequate though) reveal women's HIV infection rates closely matching those of men and in some provinces higher compared to men's. See Fig. 4. In a traditional male dominated society as PNG, and with a strong church influence, women are unable to negotiate condom use as indicated by the DHS (NSO, 1996) with a mere 2.1 % women stating ever use of male condom. Unacceptably high levels of domestic and sexual violence, particularly specific forms of brutal gang rapes called 'lainap' or 'deep line', put women in PNG society at high risk of HIV infection.

### **The Goal of NSP**

From the above statistics the gender dimension of the HIV epidemic in PNG is stark and apparent. The NSP acknowledges the vulnerability of women to HIV by recognising the heterosexual nature of the epidemic driven by multipartner sex, unequal gender relations, and high incidence of rape locally known as line-up or pack rape (NSP, 2006-2010 p.7, 10). These vulnerabilities, the document maintains, are further enhanced by PNG women's low levels of literacy, low life expectancy, limited employment opportunities, poor access to health services (p.10) and low participation of women in governance (p.9). Despite this general acceptance of women's precarious situation and position in the society, and despite an almost equal sex ratio in infection rates, the NSP has sidestepped gender as a critical concern to be directly addressed in the epidemic currently facing the

country. Gender is neither a focal theme and nor explicitly identified as a cross cutting theme to be addressed through the seven focal areas.

Given the proportion of HIV positive women in the country, a gendered response would entail women specific interventions for direct care, treatment, and economic subsistence as part of immediate response, and gender based transformation process as a long-term goal.

Recognition of gender based vulnerability to HIV is incomplete without considering the impact of the epidemic which too can be highly gendered and biased against women and girls. The NSP is silent on the nature and magnitude of the impact of the epidemic on individuals, households and communities. One reason is that there is no AIDS impact assessment done so far whether at individual or household level. Lack of the rights based approach weakens its intent to address AIDS stigma and its gender dimension. Globally, women are disproportionately burdened by the epidemic and the least likely to be among equal beneficiaries of government programs and interventions unless national policies are engendered. For example, ensuring gender sensitive access to treatment through scaled-up treatment services in Botswana and South Africa has shown a higher access by women (UNAIDS, 2004, p.100). This is the strongest reason why the gendered nature of the epidemic's impact is crucial to understand and consider in intervention designing and planning. The NSP makes no mention of the need to assess the differential impact and consequences of the epidemic on men and women infected or affected by the epidemic. People living with HIV are referred to as a homogenous body without identifying them as men and women. This apparently 'gender neutral' approach is actually a 'gender blind' approach which essentially means that it fails to appreciate how socially defined roles and norms affect men's and women's ability to protect themselves against HIV infection, cope with its impact and seek interventions for treatment, care and support. These concerns are further elaborated in the specific focal areas in the subsequent sections.

To summarise, the NSP lacks a gender explicit goal and the rights based approach that is required to address vulnerability to HIV accentuated by gender biased norms and inequalities. Engendering the goal would be a corrective action.

<b>NSP Goal:</b> To reduce the HIV prevalence in the general population below one percent by 2010, improve care for those infected, and minimise the social and economic impact of the epidemic in individuals, families and communities.
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<b>Engendered Goal:</b> To reduce the HIV prevalence in the general population by one percent by 2010, and to reduce the vulnerability of both boys and girls, men and women to HIV, and to improve treatment, care and support for all people infected and affected by HIV/AIDS, using a gender and rights based approach.
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## The Focus Areas of the NSP

### 1. Treatment, Counseling, Care and Support

The stated goal of this component is “to decrease morbidity and mortality from AIDS and related causes, to improve the quality of lives of people living with HIV, and to encourage access to VCT”.

The goal clearly is to address both the bio-medical treatment and psycho- social support needs of HIV positive individuals and must be considered significant as a more holistic approach. Another significant aspect of this goal is to provide supportive services to health workers by recognising the need for safe (healthy) work place practices and policies through provision of PEP and universal precautions. This should go a long way in allaying fears of contagion among health workers.

When outlining the objectives and strategies under this goal the NSP collectively refers to the target groups to be covered as “people living with HIV”, “risk populations”, “ health workers” and so on. For a gender- based response the identification of beneficiaries as collectives is not enough. Recognising that the needs of individuals differ along gender lines, and that existing cultural and structural barriers make it difficult for stigmatised and marginalised populations - sex workers, drug users, women- to reach services, it is important that the target groups are desegregated into more definable, relevant categories. For example, specifying beneficiaries as HIV infected men and women, male and female care givers, female sex workers, male clients of sex workers, girls and pregnant women, male and female STI patients would make for a more gender sensitive response. Breaking down the beneficiaries thus is relevant both for treatment strategies, as well as, for counseling and support interventions. The relevance of doing this is supported through anecdotal as well as social research, which show how men and women experience sickness differently and what type and level of resources are available to cope with health related problems.

#### Recommendations:

- Desegregate beneficiaries/ target groups into more relevant and intervention specific categories at the strategy levels
- Specify inclusion of health workers by the kind of gender based services they offer to ensure women and especially adolescent girls will be adequately covered in health settings

**Objective 1** aims to make ARV treatment available to 10% and 25% PLWHA in a phased manner. In male dominated patrilineal societies such as PNG, unequal gender relations and power equations work against the prioritising of women’s health care and treatment needs. Poverty and limited resources often mean men’s treatment needs are given importance over women’s needs. In households where both husband and wife are HIV positive, woman’s access to treatment is likely to be severely curtailed regardless of her health status. The NSP must ensure HIV positive women’s need to access treatment and

support is adequately met. This can be ensured only if there are sex specific targets set for treatment goal and if counselors are made aware of the need to encourage women to seek treatment. Discussions with health professionals at the PMGH revealed there were no women specific ARV enrollment facilities at this point in time and that “patients are enrolled as per the WHO guidelines regardless of sex”.

An even M: F ratio in HIV infection cases should get reflected in the equitable distribution of resources for ARV treatment. At the current rate PNG has as many women as men infected with HIV; in fact figures for 2003 report more women than men (NAC & NDoH, quarterly report, Dec 2003). Given this reality the NSP must set national treatment targets to take care of the treatment needs of growing numbers of HIV positive women. The target set in the NSP is for PLWHA in general and not by their sex category. Women seeking ANC are not mentioned as specific target group under this objective. It is essential to specify this group for treatment needs while simultaneously ensuring that women are not considered in their reproductive role alone but as beneficiaries in their own right as well.

Availability of ARV treatment may not be widely known in non-urban areas and among marginalised groups. The option must be publicised with correct information to all groups and health practitioners at all levels of care, including those in the NGO sector

**Recommendations:**

- Set sex specific national targets for ARV treatment
- Include women both as pregnant women and women outside their reproductive role for treatment interventions and set targets accordingly
- Build ARV treatment literacy among both the vulnerable sections and health workers to ensure women, female sex workers, MSM, all have the knowledge about treatment options.

**Objective 3** seeks to strengthen VCT service. VCT approach has shown mixed results in African countries. While on the one hand VCT has led to more men and women learning about their HIV status, on the other hand, some women users have been victims of violence and assault from partners (Maman et al, in press). It is important to examine relevant evidence before scaling up and to select VCT sites carefully to provide the much needed safety and confidentiality to users. Young people, both boys and girls, but adolescent girls more than others, can experience problems in using VCT service, even in non- clinic settings like NGO/CBO settings due to the fear of being identified or suspected as sexually active and due to limited mobility. Given the disturbingly high rates of infection among PNG girls aged 15-19, NSP must spell out strategies that will motivate girls and young women to avail VCT services without the fear of stigma and violence. When women get tested first and are found to be HIV positive, the threat of blame and violence increases in real terms.

**Recommendations:**

- Develop protocols for use in VCT that address the potential risks and negative consequences for women, and boys and girls

- Train VCT staff to respect the rights of users, especially pregnant women, to refuse HIV test
- Assure VCT locations are safe for use by vulnerable populations especially younger men and women and adolescent girls by locating them with general programs such as, life skills development programs
- Encourage couple counseling to safeguard partners from the vicious cycle of denial and blame

**Objective 4** aims to reduce bed occupancy rates in hospitals by strengthening family and community care support groups. The identified strategies are home based care and capacity building of family and community based caregivers including PLWHA.

The NSP strategy is rightly inspired by the strong familialistic and community oriented PNG society. Indeed there is sufficient evidence to suggest that in most traditional, community backed cultures illness and sickness is experienced within the family and community settings (See for example, Ankrah, 1991; McGrath et al, 1993, Foster, 2002). A fact sheet by WHO shows that 90 per cent of care is provided in the home (WHO, 2000). However, in recent years and more specifically in the context of HIV/AIDS, home based care approach has come under close scrutiny and careful analysis as to its usefulness and potential of scaling up (Ogden & Esim, 2003). It is important to highlight some of the assumptions and concerns related with HBC approach here. **One**, it is crucial to underscore the point that home based care is essentially feminised; the burden of care rests mainly on the shoulders of women- mothers, wives, sisters, aunts, nieces...who are expected to carry out their nurturing role (Taylor et al, 1996; Bharat, 1996; Ogden & Esim, 2003). Where men are involved, it is mainly as distant and secondary care givers (UNAIDS, 2000). **Two**, home based care burdens women in severe ways, remains invisible, unremunerated and unacknowledged thus hiding its true cost particularly when it involves long term caring as in HIV( Ogden & Esim, 2003). **Three**, informal care giving disadvantages women care providers by keeping them away from market economies, girls from attending school, and generally neglecting their own health. **Four**, while women provide care to the sick male partners, they themselves seldom receive care when they fall sick. This is especially the case in relation to concordant HIV couples (Bharat, 1996; Bharat & Aggleton, 1999). **Five**, the HBC assumes families to be embedded in a caring and supportive community while in the context of AIDS the community itself can sometimes be violently non supportive and abusive (Bharat, 2001). **Six**, and finally, the extended family system is assumed to be a ‘safety net’ for all members and at all times. The reality, however, is that the family everywhere is undergoing changes in its values and ethos and that intra-family resource allocation is highly gender biased with male members controlling and receiving more resources than female members (PANOS, 1990; Seeley et al, 1993).

Key informant interviews with a wide range of experts in PNG support the above observations. They have voiced similar concerns about relying heavily on the traditional wantok system in the context of HIV/AIDS especially in urban centers. Some of the views expressed in this connection are summarised below.

*“We are thinking that the family is a support system but I doubt it. In urban areas children are increasingly without contacts with their relatives in rural areas. These children are reluctant to assist the relatives. We are banking too much on the wantok system; it is already overtaxed. People have to help out distant relatives with school fee, bride price, funeral expenses etc and the young people in families are beginning to complain” ( Anne Waiko, gender expert, UPNG).*

*“In my experience women take a lot of care of their husbands …even when the husband abuses her, a woman continues to give care. A man may dictate the wife even from his death - bed, abuse her and curse her. But after his death the woman is at the mercy of the in-laws. I have mostly seen the mother of the infected woman laboring for her daughter” (Joe Lari, 3 Angels Care).*

*“Sometimes people dump their relatives in the hospital and disappear. Managing patients with limited resources in the homes is a big issue. If a woman is also HIV positive the family is worst off- there may not be any one to cook food even” (Dr. Goa Tau, Chief Physician, POM General Hospital).*

*“Many people are feeling neglected at home and wanting to be in a (care) center. They come to me and say I am staying with a relative but now I am fed up, I want to go to a Center. The husbands’ family does not take care of women. But her own parents and siblings do provide support” (Sr. Opina, POM General Hospital).*

The economic burden of care giving at home can be quite high but is often not costed for in HBC programs. It is assumed to be cheaper and is the classic case of the state system devolving its responsibility on to the family. The role played by subtle and not so subtle forms of stigma within the home settings is another factor to be examined when supporting HBC programs.

To sum up, the strategy of HBC and community support in the NSP is significant within the context of a traditional; culture bound society as PNG. With an overstrained public health system and limited resources for hospital based care, HBC strategy assumes further significance.

#### **Recommendations:**

- Place gender in the center of the HBC strategy such that women care givers are acknowledged and not exploited and men are not merely the benefactors but also care providers
- Ensure a gender and age mix of care providers in the program
- Give due recognition to the needs of women as primary care givers in homes and ensure that their needs for counseling, resources, information, finance and emotional support are properly assessed and met
- Ensure that families of both men and women living with HIV/AIDS are included for HBC program

- Assess the cost of home based care giving using the feminist framework of ‘care economy’ and integrate the findings in revising the HBC approach in future
- Involve men too in the affected families in care giving by challenging traditional gender roles and seeking to transform them
- Provide economic assistance to families enrolled in the HBC to alleviate the economic burden of long term care
- Ensure that school age girls in the families enrolled for HBC program are not withdrawn from school and do not suffer neglect because of older female members’ involvement in care
- Ensure that HIV positive women are equally benefited by the HBC not just through assistance in their care-giving role for HIV positive male partners but also as recipients of care and support when they fall sick and are in need of care.

The focus of **Objective no. 5** is to reduce the rate of STIs in ‘risk populations’ and ‘general population’. Available evidence suggests that PNG women’s access to any type of health services is lower than that of men. This is due to a multitude of reasons such as, lack of money to travel; safety concerns while travelling to physically remote health centers, rude behavior of staff, lack of women health workers and lack of privacy in clinics. There is an enormously high burden of untreated STIs among PNG men and women- the highest in the Asia Pacific region- with serious implications for HIV infection rates (Mgone, Passey, Anang, Peter, et al, 2002; Hammar, n.d; Lemeki, Passey and Setel, n.d.). The lack of gender sensitive services is among the major reasons for both men and women to not seek timely, adequate treatment, but even more so for women. Gender sensitive STI treatment approach can make a difference. There is evidence now to support this. Gender specific STI clinics set up under the AusAID supported STI/HIV project in NCD, Morobe, EHP, WHP, and SHP seem to be experiencing significant increase in attendance. Statistics from the Tininga (STI) clinic at Mt. Hagen hospital recorded a more than 6 fold increase in the number of women attending and improvement in the M: F ratio of attendees from 3:1 to 1.86:1 in the very first six months of the clinics gender specific service (Greg Law, NHASP). NSP strategy needs to be more explicit in terms of employing and training adequate numbers of female health staff, especially to serve rural based women and other difficult to reach populations – female sex workers, adolescent girls.

Management of STIs in women needs more than syndromic treatment because of the nonsymptomatic nature of some STIs in women. Capacity building of health staff including counselors must be tailored to this need and not to the standard regime for “STI clients”. Health professionals are usually trained for STIs among heterosexual populations. Sexual infections among people engaging in same sex behavior thus get neglected, for instance oral STIs are neglected among the MSM who avoid seeking treatment due to fear of stigma (Bharat and Aggleton, 2001).

### **Recommendations:**

- Specify that both male and female health staff will be put in place in all STI clinics with adequate privacy for ensuring confidentiality
- Train health workers in the diagnosis/treatment of a range of STIs, including non symptomatic STIs among women and oral STIs among those engaging in anal/oral sex and develop appropriate protocols
- Orient the health workers to gender issues and build their capacity for a sensitive, nonjudgmental approach in treatment of STIs

## **2. Epidemiology and Surveillance**

The goal of this focal area is to establish effective and efficient surveillance systems to provide accurate measurement and understanding of the growth and other characteristics of the HIV epidemic in PNG. The NSP's focus is on strengthening the surveillance system, improve skills of technical staff and increase sentinel sites to better capture HIV infection in the identified risk groups and the general population as well.

**Objectives 1 and 2** seek to expand surveillance activity in the country. Currently there are mainly urban sites for sentinel surveillance. The expansion of sentinel sites to provinces at district levels in the new plan should help capture the HIV infection rates better among rural men and especially among rural women with limited mobility and access to health services particularly outside their own village/district. However, there is no mention of the specific risk groups that will be specifically covered to ensure comprehensive mapping of major risk populations and of women, both at high end (female sex workers) and low end (women attending ante natal clinics) of the risk continuum. From a gender perspective it would be important to list out the specific risk groups that are expected to be targeted for sentinel surveillance, by location, to evaluate the accuracy in estimating sex desegregated HIV estimations. For example, female sex workers are vital to cover in the sentinel surveillance design. It is equally vital to state where they would be drawn from for this purpose. Besides the government run STI clinics, drop-in –centers with clinic facilities are more appropriate locations. The same would hold good for MSM as they are likely to avoid public health facilities.

With high levels of infection among girls/women between 15- 29, ANC centers are most likely to be selected as sentinel sites. However, ANC attendance is not uniformly high and this approach may, therefore, not be sufficient. Women outside their reproductive careers or those not bracketed as 'high risk' (house wives, for example) may not get full representation in the surveillance system. Using ANC attendees as proxy for the general population itself has come under some criticism in recent times.

**Objective 3** is concerned with enhancing the country information system and management of research data. The epidemiological data currently available is highly deficient with respect to even the most basic demographic variables of age and sex. For example, information about age is missing for as high as 39 per cent HIV cases in the national statistics (NACS & NDoH, 2004, p.11). Socio-demographic data is vital to understand the epidemic. The gaps need to be filled in by developing more

comprehensive protocols and sound training to the data enumerators. For a better mapping of women's vulnerability within the so-called safe relationship of marriage, questions about cultural practices like polygamy may be included. This would help assess the risk factor for co-wives which is not the same as for non regular multiple sex partners with whom condom use is likely to be higher. Questions on domestic and sexual violence will also help assess violence as a co-factor in HIV risk. Currently, a few gender specific STI clinics have been set up in Morobe and other provinces coordinated by the Institute of Medical Research (IMR), Goroka and supported through the AusAID NHASP. This project is already beginning to give estimates of HIV infection rates among female sex workers' population and patients seeking treatment for STIs. The project also collects behavioral data from patients. Estimates from this project must be used as additional data for preparing the country epidemiological report since it is likely to have community based data with adequate focus on women and behavioral risk factors.

Again, from a gender perspective it is important that capacity building of surveillance staff includes orientation and sensitisation to gender issues. The value and significance of collecting serological samples from different risk groups, including ANC attendees and female sex workers, and behavioral data, are sometimes not well understood by data/blood sample collectors. Gender sensitivity of all levels of staff is crucial to minimise the possibility of neglect during the surveillance exercise or of not attaching due importance to certain questions on say, domestic violence, in the behavioral research tool. Where possible and with due consideration to merit, women staff in adequate numbers must also be engaged in sentinel surveillance work.

**Recommendations:**

- Develop 100% accuracy in collecting data for the most basic variables of age/sex
- Specify sentinel sites with their potential to represent all the major high risk groups and the general population to ensure a gender informed epidemiological profile for the country
- Orient the data collection/surveillance staff to gender issues and impart training in collecting gender sensitive data

**3. Leadership, Partnership and Coordination**

Wherever in the world national AIDS programs have been successful, it is largely due to a strong willed and committed political leadership. Other critical factors are, strong partnerships and alliances among key stakeholders. The political leadership in PNG has come under heavy criticism for its slow and weak response to the crisis generated by the HIV epidemic. As the NSP document states "sustained political support to implement legislation and policies are not forthcoming" although the National AIDS Council Act was passed in 1997. Thereafter, the parliament supported the establishment of the NAC Secretariat, approved the National HIV/AIDS Medium Term Plan and passed the HIV Prevention and Management Act.

The NSP strives to encourage political and other leaders at all levels to give a high profile to HIV in the national agenda. **Objectives 1 and 2** aim to increase financial commitment, enhance active involvement of politicians, strengthen partnerships and build coordination capacity of the NAC Secretariat. The NSP identifies women leaders at all levels to be involved in advocacy for HIV/AIDS. But with few women elected representatives in the provincial assemblies and fewer still at the national level, it is important to expand the definition of leaders to include the ‘opinion makers’ too. The involvement of women activists, heads of women’s organisations, leading men and women writers on social issues, gender experts and academics across disciplines who can be especially effective with the youth student population must be part of the strategy. Faith/ church leaders and traditional leaders whose penetration is deeper in the peri-urban and rural settings need to be part of the leadership forum to be co-opted in HIV advocacy work particularly to spread awareness among boys and girls and women in reproductive age group. However, the church based leadership needs to revisit its role in the epidemic of PNG. There is a need to have a more open and inclusive approach to sexuality in messages and services delivered and a commitment to destigmatise the epidemic. Leadership also needs to be developed from within the corporate sector and women business leaders can be effective as role models for young women and girls in HIV education and prevention campaigns and for pushing gender friendly work place policies. The strategy to develop workplace policies in the private sector through leadership is a laudable one. While the interests of both men and women workers need to be protected, there needs to be additional emphasis placed on protecting women workers from sexual harassment and assault which may also have implications for infection with STIs and HIV. Workplace policies also need to be made non-discriminatory, PLWHA friendly and gender aware.

One of the important strategies outlined in the NSP is to enhance financial resources in line with the epidemic’s growth. Indeed financial resources for effective implementation of NSP need to be greatly enhanced but at the same time they also need to be made gender specific with committed budget for girls/women specific interventions and programs. This is particularly essential with the increasing rates of HIV infections among girls and young women in PNG. Because women in general and those infected and affected by HIV/AIDS in particular often lack direct financial resources and occupy low positions in the family resource allocations, the financial budget must not be gender neutral but gender specific. The NSP budget itself requires to be gender audited when that is put in place.

The non inclusion of PLWHA, men and women, in the strategies outlined to build and enhance leadership is a major gap in the NSP. PLWHA are among the best public advocates who can effect change from within the community of HIV positive people and be the strongest forces behind community awareness and mobilisation against AIDS. They are not listed as potential leaders in the NSP although their role in humanising the epidemic is recognised and actively sought. The NSP’s commitment to GIPA needs to be demonstrated more strongly in the focal area on leadership and partnership. Although there are constraints in this because very few PLWHA in PNG are open about their status and fewer still willing to assume public roles, the NSP must promote and support the

PLWHA movement and help set up a nation wide network of positive people. In many countries like Cambodia, Ukraine, and Thailand Positive People's national networks have successfully partnered with their governments in decision making, public advocacy and access to treatment and other care issues (UNAIDS, 2004, p.184-185). With more women becoming infected, a positive women's unit within the PLWHA network can be more effective in reaching women in both high risk areas and in the general community. Such a group will also be able to spearhead HIV prevention and advocacy with groups of women in a range of vulnerable situations like women in prisons, women in polygamous and abusive relationships, women victims of domestic violence, rape victims, sexually abused children and girls in remand homes among others.

**Recommendations:**

- Elicit a more active participation of women leaders from provincial/ village level local bodies.
- Build alliances with gender sensitive and gender aware prominent writers, academics, journalists, researchers, and other public figures and opinion makers
- Build leadership from the corporate, entertainment and sports sectors to reach out to adolescents and younger men and women
- Put in place a gender specific budget plan
- Demonstrate commitment to GIPA by acknowledging the PLWHA, men and women, as leaders for change and advocacy
- Support the creation of a women's unit within the PLWHA group for more gender based advocacy, care and support interventions

#### **4. Monitoring and Evaluation**

The NSP reflects the enhanced significance attached to Monitoring and Evaluation as a focal area towards evidence based policy development, program planning and political advocacy. The goal is to develop robust and reliable monitoring and evaluation mechanisms to track the progress of the epidemic through time and to measure the impact of the national response.

**Objective 1** is to develop an M& E framework for the national response with indicators and links with national level research bodies. This objective should explicitly state gender based reporting, monitoring and evaluation as its key strategy. All indicators must have a gender component in the process, outcome and impact evaluations. For example evaluation of training programs must not be done only in terms of number of people trained, but in terms of men/ women trainers reached, or number of female sex workers or MSM trained. To take another example, the success of VCT may be measured in terms of percentage of girls, young women, MSM, accessing the service rather than in terms of a generic number. A third example would be to measure percentage of men using condoms with regular and non-regular partners. The gender implications are better understood when the condom use is seen in relation to the type of sex partner. The kind of indicators needed for tracking the epidemic are crucial and should be decided in consultation with organisations and individuals involved in working with HIV related vulnerabilities and gender issues.

For example the generic category of sex workers masks the gender vulnerability of male and female sex workers and can be discerned by those working with them. Some important organisations in PNG to link with would be the NGO sector, government departments (for example, Dept. of Planning for inputs on gender sensitive budget); and research organisations like the Institute of National Affairs for inputs on domestic violence and rape; to name a few. It may be difficult to obtain sex specific data from sub-national levels at this point in time but the NSP must aim to achieve this for it to become a valuable tool for tracking many other development indicators. Evaluation indicators are particularly important to be made sex specific to report on the impact of the national response on girls and women's vulnerability to HIV and in mitigating its negative consequences.

**Objective no. 2** aims to support reporting on UNGASS and MDG for the country. As suggested by the WHO, Dept. of Gender and Women's Health, some of the indicators need to be suitably engendered for them to be understood and analysed in a meaningful and relevant way (See, WHO, 2003). An example is the need to collect information on sex and age specific data for MDG Goal 6/ target 7 (Have halted by 2015 and begun to reverse the spread of HIV/AIDS). HIV infection reduction among adolescent girls (15-19) and young women (20-24) will be a strong indicator that the epidemic is slowing down in PNG.

**Objective no. 3** aims to measure the effectiveness of the national response through a review of the NSP. It is vital that the indicators under this objective measure the success of the national response separately for men and women and by age groups and location (rural /urban and province). Adolescents and youth, both male and female, but females' atleast three times more than the males, are shouldering the heaviest burden of the HIV epidemic in the country. Sex based indicators would be essential to track progress in relation to the levels of efforts made to contain the epidemic within these and other risk populations. Guidelines will need to be developed for measuring impact and for analysing the results for future program planning.

#### **Recommendations:**

- Develop appropriate gender sensitive indicators to measure the impact of the national response and track the progress of the epidemic
- Incorporate gender into the process, outcome and impact evaluations
- Evaluate the NSP by gender and age based indicators
- Monitor resource allocation to programs to ensure gender equity in distribution

#### **5. Education and Prevention**

Prevention of new infections is key to controlling the spread of the epidemic and strengthening people's knowledge base about ways of prevention is, therefore, critical. The goal of NSP's prevention component is to facilitate behavior change in specific populations and increase awareness about prevention in the general population.

**Objective 1** aims to provide the population with relevant, accurate and comprehensive messages about HIV transmission. The strategies suggested are education, multi media use and culturally sensitive communication approach. Available evidence on prevention programs and strategies suggest very clearly that knowledge and information are not enough to bring about behavior change. Simply creating awareness in general population about the virus and its transmission will not address the issue of vulnerabilities of specific groups and nor equip them with ways of prevention at their level. Awareness building must also go hand in hand with removing misconceptions. For example, higher levels of awareness sometimes coexists with incorrect belief that infection is brought in by 'foreigners' and that 'familiar spaces' are also safe spaces when spousal separation following pregnancy is the norm and a reason for many men to be sexually active outside of marriage (Lepani, 2003). Similarly higher awareness does not necessarily enable people to personalise risk and identify their information needs let alone act on them. Women in this regard are particularly at a disadvantage because unequal gender relations prevent them from insisting on condoms or using one and more specifically in regular/marital relation even when they know about condoms.

From a gender perspective, what is lacking in the strategies is a) how to promote positive gender norms and practices, and b) how to address harmful and biased gender and sexual norms and cultural practices. For example, gender norms make it difficult for young people to seek information about sexuality and protection in sex from reliable sources. With cross-generational sex identified as a specific form of vulnerability in PNG, the gap in such information needs to be addressed. Girls seeking knowledge about sex may be seen as sexually active or promiscuous. Among adolescents much of the knowledge is gained from peer group which may be equally poorly informed. Qualitative studies suggest that even in societies where the young are accorded sexual freedom, discussion about sex is not encouraged and important gaps in knowledge remain. Common among these are gaps in knowledge regarding human physiology and sexuality, conception and reproduction, safer sex and the role of condoms, concepts of femininity and masculinity, and other related aspects that underlie sexual risk taking and inequality in sexual relationships. Both men and women are generally deficient in sex related knowledge base but women's need for knowledge is usually higher than that of men and needs to be filled through focused efforts. However, men are known to hold many wrong notions as well, for example about semen, masturbation, nightfall, which need to be addressed in more specific ways. Recent studies suggest that men too are vulnerable because of the societal expectations that they conform to the image of 'real men' who have multiple partners.

In the context of gender it is also important to evaluate the existing approach of using ABC messages-abstain, be faithful and use condoms- in prevention work and examine their relevance and impact in sections of populations. It has been argued that these messages miss the point when it comes to gender sensitive approaches. Most girls and women do not decide when they should begin their sex life as they are married early by parents or because they are raped and forced into non-consensual sex. It is therefore not in their hands to abstain from sex or delay the first sex experience.

The message ‘be faithful’ is also not for them as in most cases it is their male partners who are into multi-partner sex. Negotiating condom use is also fraught with difficulties because women risk abuse, violence or suspicion of infidelity if they insist on its use. Trust and intimacy and the fear of losing these also prevent many women from asking for condom use.

A very significant aspect of the epidemic in PNG is that cultural practices and norms that carried a certain value in the past are being legitimised as ‘tradition’ to the detriment of women’s interests and wellbeing. For example, women activists point out that polygamy is being practiced today in the society by men more as a way to satisfy lust than as a way of culture which valued women’s economic and producer role as much as their reproductive role and looked at polygamy as a way to strengthen the family and the clan. Today the practice of polygamy has degenerated to a form of subordinating women and satisfying men’s sexual needs. Some contend that it is nothing but another term for promiscuity. Men who can afford to bride price are taking on additional wives even in provinces where it is not the cultural practice, clearly making it a status and power symbol. It is not difficult to see how women in polygamous marriages are at a distinct disadvantage in the HIV epidemic. The ‘normalisation’ of gender based violence as a cultural feature of the PNG society has specific implications for HIV transmission rates. Education and advocacy needs to be built around it to sensitise the public and make it socially unacceptable. Another cultural practice that has a clear gender dimension is the practice of widow inheritance. The practice carries serious threat of HIV transmission to both the widow and the new husband if either of them is infected but cultural norms force them into marriage. Prevention strategies need to target the general population with knowledge about the risks from such cultural practices and the need to challenge and change or modify them. Clearly the need in education strategies is to go beyond imparting knowledge about the virus and the modes of transmission to raising public awareness about the gender based vulnerabilities and risks resulting from an uncritical following of cultural practices. One strategy to do this would be to educate the public about customary practices and traditions – the benefits as well as associated responsibilities.

The emphasis on employing culturally appropriate communication strategies in the NSP is appreciated. It will be useful to also adopt a gender sensitive approach in messages which essentially means avoiding gender stereotyping and avoiding images and content that may stigmatise particular groups. For example, the image of a woman with a child, both HIV positive, and the caption “This could be your story” may convey the message that women transmit the virus to their babies where as in reality both parents are involved in vertical transmission. For the same reason it is important to engender the language of HIV messages and use PPTCT – prevention of parent to child transmission – and not MTCT, for instance.

The stakeholders in program design should be spelt out to represent all key categories, especially of young men and women and young male and female PLWHA.

What is required essentially in prevention strategies is to transform gender relationships in society. While this is clearly a long-term strategy, a beginning needs to be made and the HIV epidemic may be used as an opportunity to do so.

**Objective 2** aims to target risk groups for interventions. Education is again a strategy but preventative efforts are not mentioned and it is not clear how these would address gender-based needs of the different target groups. For example what specific interventions will be made viable for preventing vertical transmission. The target population is listed and includes marginalised groups with some sex balance as well. However, some of the target group will need to be further disaggregated as they are far from being homogenous. Take for example the case of ‘women’. There is some evidence that women sex workers are probably better protected as male clients use condoms with them more often than they do with their wives and other non commercial regular partners. So, the risk of wives and regular partners need to be specifically addressed. Even among them, the wives of bridge populations are at higher risk than others – i.e. the spouses of male mobile populations, men in polygamous unions, and MSM since many of them are also bisexual and married.

The aim of **Objective 3** is to increase safer sexual practices among the sexually active population, with focus on youth. Condom promotion is the main strategy to the exclusion of other possibilities like non-penetrative sex. It is not specified whether this strategy will also include promoting female condoms. From all available evidence it is suggested that women are unable to demand condom use from their partners. Therefore female condoms need to be promoted in a large way. There is some evidence that their acceptance is good among PNG women. A gender-balanced approach would also be to promote condoms as dual protection device- i.e. for family planning and for disease prevention. Women using contraceptives like oral pills or who are sterilised may not understand the need for using condoms, and their men too may not perceive them as offering protection against diseases.

#### **Recommendations:**

- Integrate gender into all education and prevention strategies
- Develop and support activities that seek to transform gender norms and relations in society as the key approach
- Support the use of information channels that are uniformly available to men, women, boys and girls, in rural areas and to illiterate populations
- Make all information material gender sensitive, particularly avoiding gender stereotyping – men in dominant provider role or women as victims
- Examine the existing education and prevention approaches, for example the ABC approach, from a gender perspective to understand how gender operates in the interpretation and adoption of health messages
- Develop gender sensitive BCC programs based on the understanding of contextual factors for specific groups: male clients of sex workers, migrant and mobile populations, mining workers, adolescent girls and boys, professionals, and so on
- Develop education programs that address basic and gender biased misconceptions in relation to HIV/AIDS

- Develop education programs to address gender and sexuality, and to fill gaps in knowledge on reproductive and sexual health of all groups including men
- Develop strategies and education programs to raise public awareness about issues like cross generational sex, domestic and sexual violence, and the harmful and negative consequences of certain cultural and traditional practices in regard to HIV
- Specify target groups under all interventions by sex and age to ensure gender sensitive programming
- Develop programs for promoting female controlled methods of safer sex
- Promote condoms as dual protection device

## 6. Family and Community Support

The NSP acknowledges quite succinctly the gaps in existing care and support measures for PLWHA and the climate of fear and stigma and discrimination that surrounds the epidemic. The goal therefore is to support and sustain a social and cultural environment that will enable families and communities to care and support people infected and affected by HIV. The focus is on increasing access to services, building a supportive environment, respecting human rights and supporting orphan and vulnerable children (OVC).

**Objective 1** aims to increase access to community based support services for PLWHA. One of the strategies is to involve PLWHA in community education programs, which would mean disclosure of their sero status. Already PLWHA are being asked to return to their provinces to help in awareness building efforts (The National, Oct. 4, 2004, p.6). PLWHA are among the best advocates but stigma is a real threat in their lives particularly in the lives of adolescent girls and women. Female sex workers who are HIV positive are stigmatised in more ways than one – as women, as sex workers and as HIV positive women. Similarly, HIV positive MSM carry the double stigma of having an alternate sexuality as well as being infected with HIV. PLWHA needs for safety and security thus needs to be ensured before they are thrust with this role.

Families and communities are indeed the first lines of defense in crisis of any kind in most developing societies like PNG. However, in male dominated culture men control community as well as family resources. Decision making also rests with the male members. It is likely that communities and families will place the needs of one member over another; in patrilineal society the needs of men may dominate while in the matrilineal society it may be the reverse of this. Care must be taken to train community members to respect and consider the needs of both men and women equally and in keeping with their health status. The strategy to involve families and communities in resource strapped countries and where public health structure is weak, is a good strategy. It also merits attention for encouraging community participation. But this approach is often based on the assumption that household and community resources are equitably distributed between men and women and adults and children. The strategy will need to be carefully developed to be sensitive to some of these issues and orient communities accordingly. The strategy to support family care giving is again a very important one, but runs the risk of overburdening women, young girls and older women, as most family based care is feminised.

The increased burden of care may prevent women from engaging in routine productive and home making tasks and girls from attending school. Male involvement in community and family support should be an integral part of the proposed strategy.

**Objective 2** aims to reduce stigma and discrimination through community support structures. Sensitising communities and making them more tolerant and accommodative is important for long term gains. The nature, forms and contexts of stigma and discrimination, however, need to be better understood to translate this strategy into action. Gender norms influence the way HIV positive men and women are perceived in society. While men's sexual behavior is condoned, women's is judged more harshly. Male needs for sex when away from their spouses and partners are somehow legitimised and normalised while sexual transgression on women's part is morally rebuked. Women are generally considered to be the vectors of the virus and blamed and shamed more than men. There are stories of women being thrown out by their in-laws, their houses burnt, and stories of neglect and apathy from families and communities. This is not to say that men do not experience stigma and discrimination; quite to the contrary. But the experiences differ along gender lines and so do their needs. Care givers and community members need to be sensitised about the gender dynamics of stigma in capacity building programs.

The focus on pregnant and lactating women is important but it is equally important that women's care issues are not tied to their reproductive and nurturing roles alone. Women with HIV/AIDS must be able to access and receive care and support in their own right as women.

**Objective 3** seeks to recognise and protect human rights and access to care and support within the response to the epidemic. Human rights are key to HIV prevention and control objectives. A rights based approach has yielded positive results in countries like Uganda and South Africa. Human rights issues, however, are sometimes narrowly understood as rights to consent and confidentiality alone. The concept includes protection of people's right to earn livelihood, right to health, right to marriage and found a family, right to information and access to resources among others. From a gender perspective women's right to inheritance, maintenance and property need to be underscored as being important for their basic survival and protection of their children's future. PNG customary laws do not give women the right to own land or to inherit her husband's property through her male children or if she agrees to being inherited (men in matrilineal societies are similarly affected). Women who have no male child or who do not wish to be inherited may face survival threat. Lack of property and inheritance rights impoverish women and severely impact their access to productive resources pushing many of them into sex work. The strategy therefore needs to focus more sharply on women's human rights issues in the context of the epidemic. Women's rights are further compromised in the epidemic when they are in a polygamous relationship.

The state law may protect the right of the first wife to benefits (that may accrue in the case of those employed) but will not protect the rights of the co-wives who are infected by the husband the same way, as was the first wife. In some cases the first wife may not be infected if the husband did not sexually favor her but the younger wife(s) may be, but her claim to benefits may still not be accepted under the employment laws. The AIDS Act also needs to be examined from the point of multiple infections (i.e. infections within the cohort of co-wives of a man) within a household and the rights of all infected women to maintenance and protection. It is important that the strategy to deal with human rights issues identifies the need to review customary laws and their impact on women in the context of the epidemic and address the need for reforms in the same.

The strategy also needs to ensure that spouses (in most cases it pertains to wives more than the husbands) of positive people are not stigmatised because of their HIV status and that women are not blamed and shamed if their children are also found to be positive.

In view of rising cases of pediatric HIV and deaths of parents due to AIDS, objective no. 4 assumes special importance. The strategy of identifying children of positive parents, however, may lead to stigma. Estimation of OVC is an important strategy and must be done by sex and age categories at the minimum. OVC may be vulnerable to sexual exploitation and girls more than boys. Limited resources may mean prioritising but sex selective prioritising must be avoided. Building care of OVC into traditional safety nets is a useful strategy but again girl children can be at a disadvantage of being neglected for their nutritional and educational needs and sexually abused by family and clan male members.

#### **Recommendations:**

- Develop a supportive environment for PLWHA to disclose their sero status and serve as advocates by developing mechanisms for the protection of their rights to treatment, care, information and right to earn and for addressing stigma and discrimination
- Incorporate the HBC strategy with programs on income generation (micro credit programs) and food security to support HIV infected and affected households with no income
- Develop programs to sensitise communities about gender and HIV vulnerability issues
- Involve men in the care of positive family members through the HBC program
- Conduct gender specific needs assessment among PLWHA and other vulnerable populations to assess gaps in services
- Assess the information, education and counseling needs of communities involved in support initiatives for infected and affected populations
- Adopt a gender and rights based approach in all HIV related interventions and programs
- Address gender disparities in customary laws and practices through reviews and reforms in laws of property and inheritance and family laws in relation to HIV/AIDS
- Recognise and address the vulnerability of co-wives to HIV in customary polygamous relationships and address issues like lack of rights of co-wives to claims in property and employee benefits

- Estimate OVC by sex and age to address their needs in gender specific ways

## 7. Social and Behavioral Change Research

A robust database is the foundation over which a program rests and has the potential to succeed. The need for scientifically designed robust research studies can not be overemphasized. The goal of NSP is to improve social behavior research in PNG to compliment the epidemiological data and guide interventions for behavior change.

The aim of **Objective 1** is to build and strengthen research capacities in the country. It will be important to build capacities for undertaking both quantitative as well as qualitative research. The latter would be crucial to carry out exploratory, community-based research with marginalised and hard to reach populations. Qualitative research is extremely useful in gender studies. Research capacities are technical in nature but also require staff to be sensitive and adequately oriented to gender issues and concerns. Staff training may therefore incorporate topics on gender and research ethics.

**Objective 2** seeks to increase the database of the country. A gender sensitive response will mean that the scope of research is not limited to understanding the sexual behavior in PNG but the entire continuum of risk and vulnerabilities that place men and women in difficult situations and promote risk taking. Anthropological research, past and current, on PNG provides a useful basis for understanding the cultural context of vulnerabilities to HIV. There is some good data on sexual culture, sexual networks, select 'high risk' groups and cultural construction of STIs and treatment seeking behavior, and others. However, gaps exist in the understanding of the social construction of gender and the role of socio-cultural factors-economic, social, cultural, political, structural- in the PNG society, in relation to HIV related risk behavior and vulnerabilities. For example, it is important to examine the role of gender in influencing sexuality related vulnerability and the role of societal norms and ideologies of masculinity and femininity in influencing risk behavior. It is also important to understand the cultural context of sexual violence and its influence on women's development, general well being and health status. Given the high infection rates among female adolescents and young women, it is important to understand how gender intersects with age to enhance vulnerabilities.

As before, from a gender perspective it would be important to explicitly name the research populations. Adolescents are an under-researched group in many societies and in view of their critical position in the PNG epidemic, female adolescents and young women should be important groups for research. Research on men of all ages is scant, particularly in relation to masculinity and male sexual health. The emphasis on them is usually as male clients of sex workers and as migrant/ mobile populations. The need is to understand male behavior outside of a 'disease' and 'problem' paradigm. The other group critical for research would be MSM. This seems to be a hidden and highly stigmatised group but its role in the epidemic is important to examine especially as they are likely to be serving as bridge population for the general community. Again the PLWHA group needs to be desegregated by sex for research purpose for designing gender appropriate and needs based interventions.

Condom use research though important limits women's options for safer sex. Further research is needed on female condoms and on other female methods and products like microbicides.

There is a huge gap in research on the socio economic impact of the HIV epidemic on individuals- men, women and children; on households – intra household dynamics, relationships and resources, care and support, and on communities. In relation to care and support issues research on the topic of 'care economy' will guide interventions like HBC. Research is also required to understand the role of stigma and discrimination as barriers to knowledge seeking, to testing, and adopting safer prevention options and in individual health seeking behavior. This should be done with both men and women living with HIV. A gender sensitive response would be further strengthened by undertaking a systematic review of customary laws that have implications for the epidemic- both in terms of fuelling gender vulnerabilities and in accentuating its impact on women.

**Objective 3** seeks to build a database for evidence backed strategy designing. Among the organisations listed for networking and collaborating, women's organisations and research groups would be critical. Several of these exist in PNG. A structured electronic database would be useful to track the epidemic over time in PNG with respect to key indicators for evidence based political advocacy. The indicators desegregated by sex will strengthen the national response.

#### **Recommendations:**

- Build capacities of national researchers to carry out gender focused research through both quantitative and qualitative research approaches
- Promote research on gender and sexuality to examine norms of masculinity and femininity, culture of sexual violence, risk taking in sexual behavior, sexual relationships and couple communication, notions of healthy sex, sexual desire and pleasure seeking, to name few areas
- Promote research on men, adolescent girls and young women, MSM and other bridge populations such as mobile men
- Conduct gender specific needs assessment of PLWHA
- Assess the socio economic impact of the epidemic on men, women, households and communities and particularly the issue of care economy
- Document and analyse the issue of AIDS related stigma and discrimination and the gender dimension of the problem in PNG
- Develop research proposal guidelines to promote gender sensitive research design and adopt selection criteria for NGOs/interventions to support organisations that are gender sensitive and possess capacity for gender analysis and planning

#### **The scope to integrate Gender in NSP**

The National Strategy Plan on HIV/AIDS for PNG has been endorsed by the National Executive Council of the country. According to the NAC Director the NSP is ready for implementation.

The recommendations for integrating gender into the plan are beginning to be examined as part of ongoing activities. The Monitoring and Evaluation framework for the NSP, for example, has integrated relevant aspects of the gender audit report into the framework. Discussions carried out with key stakeholders and partners as part of this gender analysis exercise has revealed a high level of interest in the gender dimensions of the epidemic in PNG. However, there is only a rudimentary level of understanding of gender on the part of a majority of stakeholders and most certainly only very basic level of knowledge of how gender intersects with the epidemic and what might be its relevance for strategies and activities identified in the NSP. A few of the stakeholders interviewed said there were “no gender issues in PNG’s HIV epidemic”. Most could not explain the even sex ratio in PNG’s epidemic and the higher levels of infections among teenaged girls were attributed to their “promiscuous behavior and greed for quick money”. The tendency among some, mostly male stakeholders, was more to attribute blame on girls and less on relating it to the economic and social vulnerability of girls to sexual advances of older men. Besides the issue of inadequate understanding of gender there are other challenges that might pose some difficulties in integrating gender into the NSP even at the implementation stage. Some of these are,

- A low level of awareness and sensitivity about gender issues among policy makers, parliamentarians, and senior bureaucrats;
- Only one woman parliamentarian in the country and only eight provinces out of 20 have women representatives at the Provincial Assembly level so the voice of women is muted at the national decision making platform;
- Male dominated decision making structures in most government departments are gender biased and resistant to pro – women activities and programs;
- Low level capacity at the national level and still lower at the level of provinces and districts to carry out gender sensitive programs and training;
- Deeply entrenched gender biases and attitudes and high level of crimes against women, especially sexual crimes that are sought to be explained away in cultural terms and somehow normalised;

The country offers several opportunities though to make the national response to HIV more gender sensitive. Some of these are,

- PNG government is a signatory to many international conventions that support women’s empowerment such as, Universal Declaration on Human Rights, Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), Beijing Platform of Action, Pacific Platform of Action, International Conference on Population and Development (ICPD), Convention on the Rights of the Child (CRC), and Millennium Development Goals (MDG);
- The national constitution guarantees equality to all its citizens regardless of sex, and other considerations;
- National Policies such as, Medium Term Development Strategy ( MTDS , 2005-2010), National Population Policy ( 2000-2010), National Women’s Policy, Gender Policy in Education ( 2003), the National Platform of Action are in effect;

- The National AIDS Council Act ( 1997) and the HIV/AIDS Management and Prevention Act( 2003) are in place;
- Increasing government partnership with women's organisations particularly around issues of violence against women, family violence ( Family Violence action Committee- FVAC), child abuse, girls empowerment through education, among others;
- Emerging women leaders at the local, district levels;
- Research and documentation on the social and cultural dimensions of societal problems;
- Partnership with UN Bodies and an expanded donor support

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## Appendix 2. Key concepts related with gender

**Sex and Gender.** These two terms are sometimes used interchangeably but in reality they mean different things and these differences have important implications for policies and programs. The term ‘**sex**’ refers to the physiological attributes that a person is born with and that identify the person as male or female. These include the genital organs, the type of hormones in the body, the ability to produce sperm or ova, the ability to give birth and breastfeed. These biological differences that are given and predetermined can also be the sources of risks and vulnerabilities for men and women. For example, early initiation of sex in young girls puts them at higher risk of HIV infection because of the fragility of their vaginal epithelia and immaturity of the cervix.

The term ‘**gender**’ is understood as “the widely shared expectations and norms within a society about appropriate male and female behavior, characteristics and roles, which ascribe to men and women differential access to power, including productive resources and decision making authority” (UNAIDS, 1999). Gender is socially constructed and deeply rooted in the social norms and values prescribing sets of rules to guide the behavior of boys and girls, men and women. Gender influences the ways in which society determines productive and reproductive roles and responsibilities of men and women and their access to resources. Gender is not a fixed entity unlike sex, but a dynamic concept amenable to changes in the environment although slowly and gradually. For this reason gender stereotypes and inequalities can be challenged and targeted for change.

**Gender relations** refer to the ways women and men relate to each other in their daily lives and in specific situations as individuals or as part of a dyad or a group. In nearly all societies gender relations are asymmetrical and underlie the oppression and discrimination experienced by women. Although men are also sometimes discriminated, for example men from minority status, but through out history it is women who are overwhelmingly disadvantaged and discriminated due to asymmetrical gender relations.

**Gender audit**, usually used in reference to gender budget, is a tool of gender mainstreaming process. Gender audit seeks to analyse government policy and programs from a gender perspective. The underlying assumption of gender audit is that public policy and programs address and impact men and women differently and the goal of a gender audit is to make public policy and strategies equitable from a gender perspective. (Based on Barbara Swirski, What is a gender audit, 2002).

**Gender Mainstreaming.** The United Nations Economic and Social Council (ECOSOC) has defined the concept of gender mainstreaming as follows:

“ Mainstreaming a gender perspective is the process of assessing the implications for women and men of any planned action, including legislation, policies or programs, in any area and at all levels.

It is a strategy of making the concerns and experiences of women as well as of men an integral part of the design, implementation, monitoring and evaluation of policies and programs in all political, economic and societal spheres, so that women and men benefit equally and inequality is not perpetuated. The ultimate goal of mainstreaming is to achieve gender equality" (ECOSOC, 1997).

Gender mainstreaming does not mean adding on a “women’s component” and nor does it restrict itself to inclusion of an agenda like “gender equality”. In its broadest sense it involves enhancing women’s and men’s participation equally at all levels and empowering both to influence decisions, agendas, processes and outcomes in keeping with the goals of development.

Gender mainstreaming is increasingly being recognised as a useful strategy in HIV/AIDS response. With the growing recognition of a strong gender dimension of the HIV epidemic, it is becoming clear that balancing gender relations and power equations and ensuring fair distribution of public resources between men and women is critical to developing a response to the epidemic. Gender mainstreaming strategy seeks to analyse all elements of an existing public policy to ensure gender concerns are adequately and appropriately addressed in the policy design, program planning, research, implementation, and monitoring and evaluation.

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Table 1: HIV infections in PNG ( Jan 1, 2003- Dec 31, 2003)

Age group	Male		Female		Sex Not Recorded	Total
	No.	%	No.	%		
< 2 year	06	01	11	01	00	17
2-9 years	33	05	44	06	02	79
10-14	05	01	13	02	00	18
15-19	32	05	82	11	01	115
20-24	56	09	175	23	02	233
25-29	104	17	159	20	01	264
30-34	127	20	136	16	05	268
35-39	100	16	77	10	05	182
40-44	69	11	46	06	03	118
45-49	37	06	15	02	02	54
50-54	31	05	15	02	02	48
55-59	13	02	02	00	00	15
> 60	10	02	01	00	00	11
Total known by sex & age	623	59	776	66		
Total unknown by sex /age					23 n.k by sex 115 n.k by age & sex	
Total unknown by age	440	41	392	34		832
Total	1063		1168		138	2369
<b>Total M+F = 2231</b> <b>% of all cases known by sex ( Male = 47.64%; Female = 52.36)</b>						

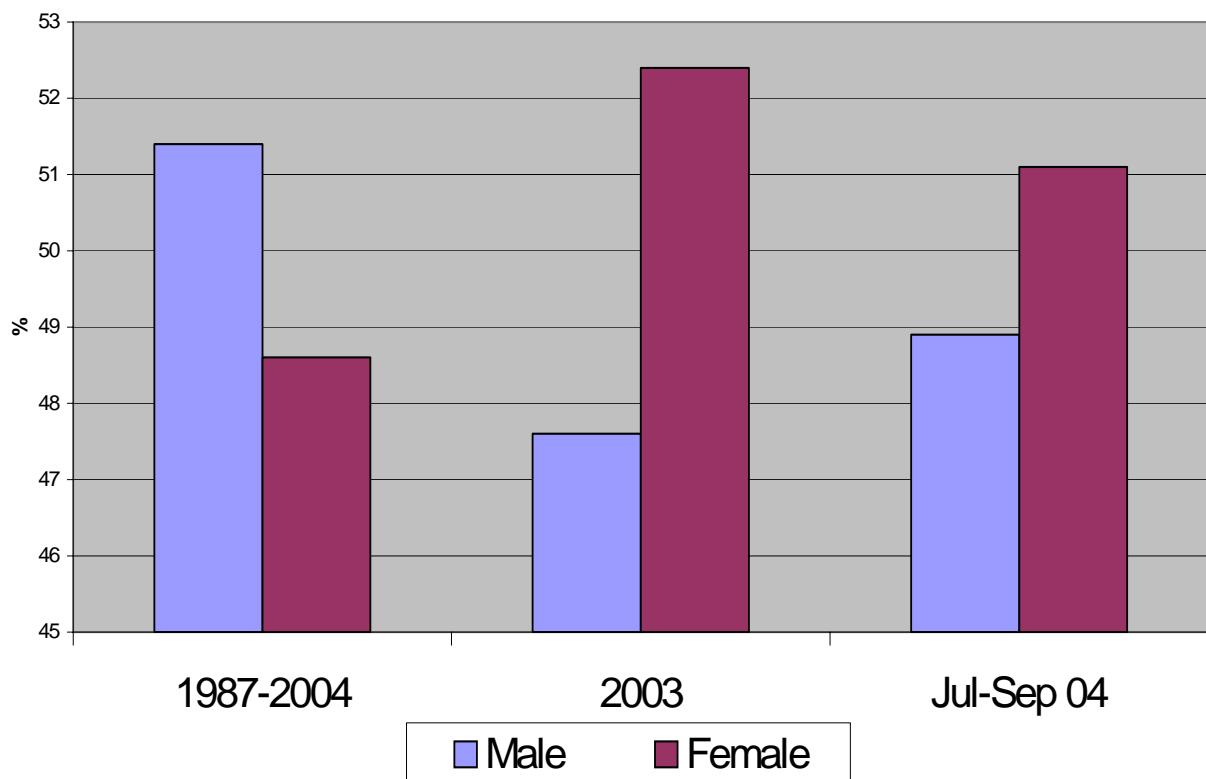
(Source: Based on National AIDS Council Secretariat & Dept. of Health, HIV/AIDS Quarterly Report, December, 2003)

Table 2: HIV infections in PNG ( July 1, 2004- September 30, 2004)

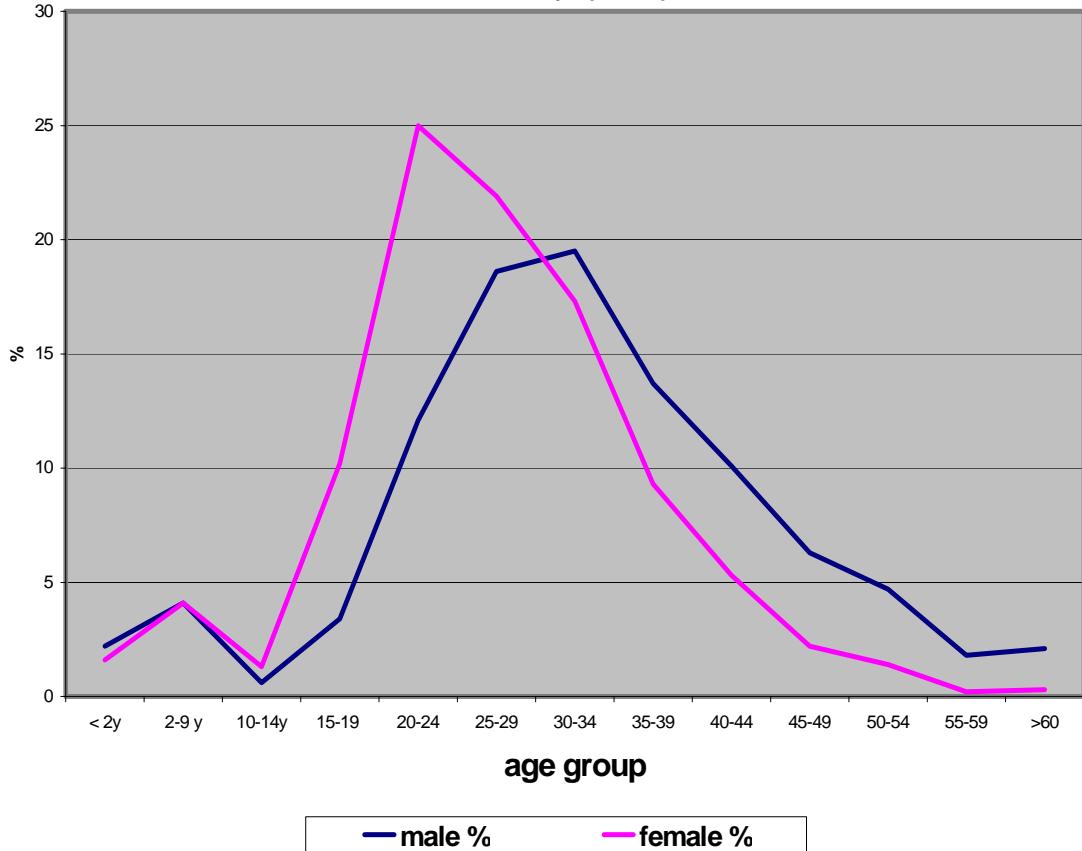
Age group	Male		Female		Sex Not Recorded	Total
	No.	%	No.	%		
< 2 year	01	1.0	00	00	00	01
2-9 years	07	6.1	11	8.8	00	18
10-14	02	1.7	02	1.6	00	04
15-19	03	2.6	09	7.2	00	12
20-24	13	11.3	38	30.4	00	51
25-29	24	20.1	25	20.0	00	49
30-34	19	16.5	20	16.0	00	39
35-39	13	11.3	12	9.6	00	25
40-44	13	11.3	05	4.0	00	18
45-49	05	4.3	02	1.6	00	07
50-54	09	7.8	01	1.0	00	10
55-59	03	2.6	00	00	00	03
> 60	03	2.6	00	00	00	03
Total known by sex & age	115		125			
Total unknown by sex					14	
Total unknown by age	62		60			112
Total	177		185		14	376
<b>Total M+F = 362</b> <b>% of all cases known by sex ( Male = 48.9 % ; Female = 51.1 % )</b>						

(Source: Based on National AIDS Council Secretariat & Dept. of Health, HIV/AIDS Quarterly Report, September, 2004)

**Fig.1:Distribution of reported HIV cases in PNG by sex in different time periods (NACS & DoH, PNG, Quarterly report, sept. 2004)**



**Fig. 2. HIV infections in PNG by sex and age (in %) 1987- Sept.2004**  
NACS &DoH, Quarterly report, sept. 2004



**Fig. 3 : % HIV Infections in PNG for Cases Recorded by Age and Sex  
( Jan 1- Dec 31, 2003)**

